A THRESHOLD QUESTION: HOW DO PAYMENT AMOUNTS IN MEDICAL MALPRACTICE CLAIMS RELATE TO THE MEDICAL CARE RENDERED?

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BACKGROUND

The National Practitioner Data Bank (NPDB) began operating in September 1990 and is administered by the Department of Health and Human Services (HHS). It comprises mandated reports of payments made "under a policy of insurance, self-insurance, or otherwise, in settlement (or partial settlement) of, or in satisfaction of a judgement in, a medical malpractice action or claim", as well as reports of adverse licensing and privileging actions taken against licensed health care providers.[1] By November 1993, 59,369 reported malpractice payments represented 83 percent of all NPDB entries. [2]*

The rationale of using a malpractice payment as a trigger for reporting providers has been vigorously debated in both public and private sectors since the NPDB was conceived. One legislative impetus for establishing the NPDB was to respond to "a national need to restrict the ability of incompetent physicians to move from State to State (sic) without disclosure or discovery of the physician's previous damaging or incompetent performance."[3]

Reporting malpractice payments would appear to comport with legislative intent only if those payments, in fact, reflect damaging or incompetent professional performance. In reality, however, payments are often made in malpractice cases by practitioners or their insurers when adverse clinical outcomes have occurred despite the provision of professionally competent health care.[4]

The reasons for paying legally nonmeritorious cases vary considerably. Often the payments are based upon a summary determination that the combined costs in money (expended and at risk), time, and emotional distress involved in litigating an assertion of professional negligence outweigh the combined costs of settlement.[5] As the monetary amount required to settle a case decreases relative to the total costs of contesting a patient's assertion of professional negligence, the likelihood of settlement increases.

Reporting cases that involve smaller payments might be less likely to target those whom Congress intended when establishing the NPDB, i.e., "incompetent physicians." Further, one could argue that reporting every payment may actually thwart legislative intent by being overly inclusive, thereby blurring the distinction between competent and incompetent health care providers. In addition, if every "nuisance" settlement is reported, the number of cases fully litigated in court will necessarily increase.

One proposed response to these concerns is to use a reporting threshold based upon amount paid. The American Medical Association and the St. Paul Fire and Marine Insurance Company, one of the nation's largest professional liability insurers, advocate a threshold amount of $30,000.[6] Smaller payments would not be reported to the NPDB. The American Hospital Association and the Physician Insurers Association of America advocate a threshold of $50,000.[7]

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*The Departments of Defense and Veterans Affairs generally report only paid malpractice cases in which peer reviewers have determined that the standard of care was not met.

Supporters of a reporting threshold argue that it would limit litigation to economically significant cases, reduce administrative burdens on reporting authorities and those maintaining the NPDB, and promote greater fairness to health care providers, primarily by discounting nuisance value settlements.

The relationship of malpractice payments to the occurrence of substandard care has not been analyzed previously with a computerized database. This article examines that relationship, using the Department of Defense database of closed malpractice claims, Tort-2, and considers the effect selected reporting thresholds might have on the NPDB.

An earlier issue of this publication provided an extensive discussion of the computerized database that was used for this article.[8] In 1988, the Office of the Assistant Secretary of Defense for Health Affairs began collecting specified data on all closed malpractice cases brought against the Department of Defense. When this article was written, Tort-2 included 1,932 cases that had alleged professional negligence by health care providers.

FINDINGS

A determination whether the standard of care was met or not met had been made by senior reviewers in each service's Office of the Surgeon General for 1,750 cases. Nearly 200 cases in which the standard of care had not been able to be determined were excluded from this analysis.

The upper left chart in Figure 1 depicts the breakdown of the standard of care (SOC) determinations for those 1,750 cases. In 560 cases (32 percent), peer reviewers determined that the standard of care had not been met (SOC not met). Nevertheless, payment occurred in 713. The standard of care was determined to have been met (SOC met) in 55 percent of those paid cases. (See upper right chart in Figure 1.)

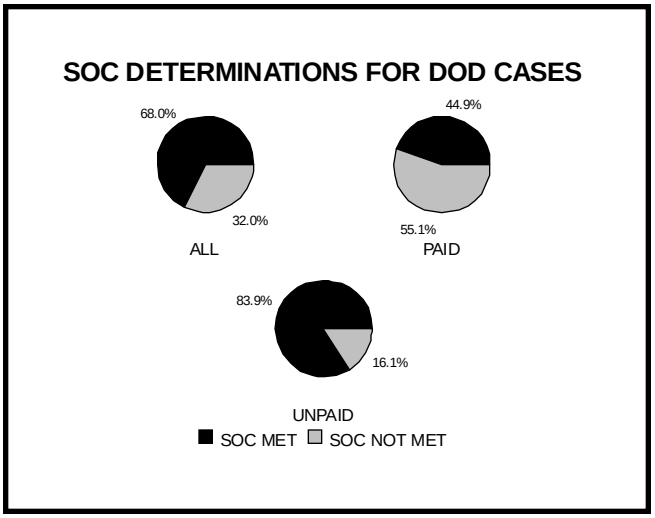

FIGURE 1

Of the 1,037 unpaid cases, the standard of care was not met in 16 percent (lower chart in Figure 1). Unpaid cases in which the standard of care was not met include those in which there was no compensable injury, those in which the substandard care was not the cause of the claimant's injury, and those with a procedural flaw, such as exceeding the allowable time for making a claim.

The charts in Figure 2 depict standard of care determinations for three payment ranges: $1 -

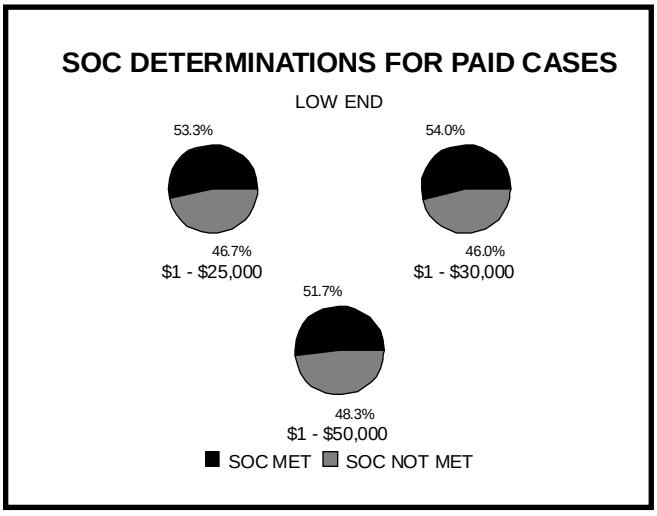

FIGURE 2

$25,000, $1 - $30,000 and $1 - $50,000. There were 315, 328 and 387 cases involving payments of up to $25,000, $30,000 and $50,000, respectively. The percentage of paid cases in which the standard of care was met did not vary significantly for these amounts (53, 54 and 52 percent).

The charts in Figure 3 depict the standard of care determinations for three payment ranges over $25,000. There were 398, 385 and 326 cases involving payments of at least $25,001, $30,001 and $50,001, respectively. From a different perspective, these charts represent the hypothetical results if reporting thresholds were set at $25,000, $30,000 and $50,000. Even with a $50,000 threshold, nearly 4 out of 10 paid cases were for those in which the standard of care had been determined met by senior medical reviewers. Moreover, no significant difference appeared to result from raising the threshold from $25,000 to $50,000.

Table A reports the percentage of claims, for selected payment categories, in which the standard of care was not met. The table confirms the impression obtained from the figures that not only the fact of payment alone but also selected payment **amounts** seem poorly related to determinations that the standard of care was not met.

Using various payment thresholds does prevent many cases in which the standard of care was met from being reported to the NPDB. It also, however, dramatically decreases reports of cases arising from substandard care. Further, although it seems inequitable to report all paid cases, regardless the amount, the cost in missed cases of substandard care would likely be substantial, were a threshold used.

Table B summarizes information comparing threshold amounts with the numbers and percentages of SOC met cases that would have been reported to the NPDB, if all paid Tort-2 cases were reported. It reemphasizes the minimal effect that thresholds would have on reducing the percentage of cases reported when the standard of care was met.

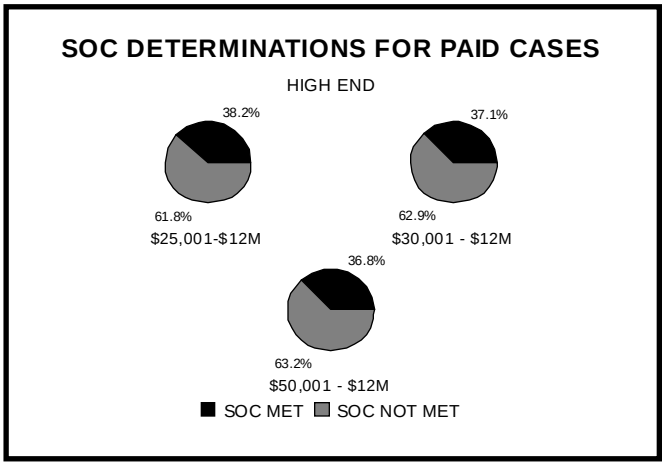

FIGURE 3

SOC NOT MET DETERMINATIONS (%)
FOR SELECTED PAYMENT CATEGORIES

PAYMENT CATEGORY	SOC NOT MET DETERMINATIONS
Unpaid Cases	16%
$1 - $25,000	47%
$1 - $30,000	46%
$1 - $50,000	48%
$25,001 - $12,000,000	62%
$30,001 - $12,000,000	63%
$50,001 - $12,000,000	63%
All Paid Cases	55%
All Cases	32%

TABLE A

SOC MET CASES REPORTED
USING VARIOUS THRESHOLDS

THRESHOLD	NUMBER	%
All Cases Reported (1750)	1190	68.0
All Paid Cases Reported (713)	320	44.9
Above $25,000 Threshold (398)	152	38.2
Above $30,000 Threshold (385)	143	37.1
Above $50,000 Threshold (326)	120	36.8

TABLE B

As a corollary, Table C indicates the numbers and percentages of cases in which the standard of care was not met that would go unreported if various thresholds were imposed. The effect appears significant. If the threshold is raised to $50,000, over 63 percent of the 560 cases in which the standard of care was not met would remain unreported.

SOC NOT MET CASES UNREPORTED USING VARIOUS THRESHOLDS

THRESHOLD	NUMBER	%
All Paid Cases Reported	167	29.8
Above $25,000 Threshold	318	56.8
Above $50,000 Threshold	354	63.2

TABLE C

One purported benefit of employing a threshold is an easing of administrative burdens on the reporting authorities and those maintaining the NPDB. Currently, DoD reports only those paid cases where the standard of care has been determined to have not been met. Imposing a reporting threshold for virtually any payment amount will necessarily reduce the number of cases reported to the NPDB.

Figure 4 illustrates the potential reduction in reporting caseload, using Tort-2 data, if various thresholds were imposed. The dark bars display the percentage reduction if standard of care determinations were made, as in DoD, and those determinations controlled the cases reported. The light bars indicate the percentage reduction if all paid cases were reported, as purportedly occurs in the civilian sector. The easing of administrative burdens would be greater for the civilian sector than for DoD, since DoD already has a reporting "threshold", i.e., SOC met cases are not reported.

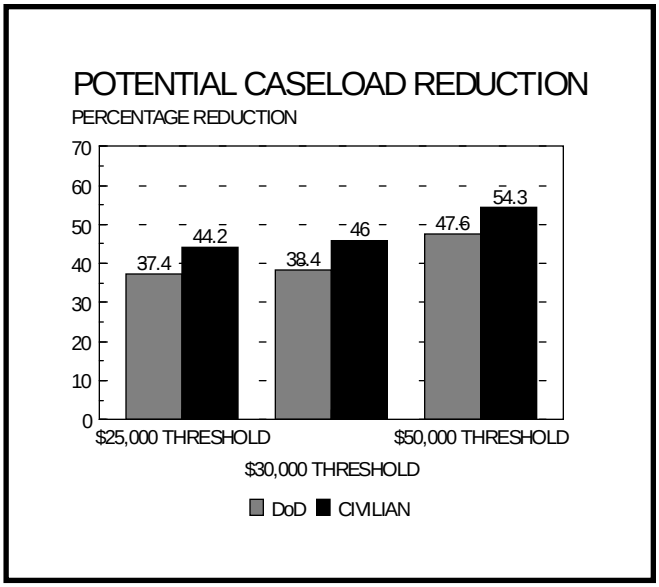

FIGURE 4

DISCUSSION

In 1988, after the passage but before the implementation of the law creating the NPDB, the Secretary of HHS invited comments from all interested parties.[9] More than 140 comments were submitted. Of those, "more than 50" concerned the reporting of medical malpractice payments, and the majority of those "expressed concern over the burden of reporting all payments, regardless of size."[10] Many respondents suggested setting a threshold.

The law was implemented without a threshold because HHS maintained that, due to statutory language, all malpractice payments were to be reported. Nevertheless, HHS noted that the Secretary would be filing a report to Congress and addressing the issue of reporting small payments. Subsequently, in his report, Secretary Louis Sullivan indicated support for a threshold of $30,000.[11] Today, the issue remains unresolved.

This article involved an analysis of 1,750 closed medical malpractice claims against DoD. These claims comprise an unusual group in that the medical care from which they arose has been subsequently scrutinized by professional peers. Standard of care determinations were made for every case. Both malpractice claim payments and payment amounts correlated poorly with the standard of care determinations.

In addition, hypothetical reporting thresholds were imposed on this group of malpractice claims. The "fairness" of reporting payments does not appear significantly improved by imposing an arbitrary series of thresholds.

There are even some threshold opponents who maintain that the discriminatory value of any threshold would be minimal. They argue that claims up to the threshold would be expeditiously paid and those in excess challenged vigorously. Many settlements would occur just under threshold. Simply put, some people would "game" the system.

If setting a threshold does not resolve the fairness issue, it may likewise have little effect on litigation. Trials are often avoided for small claims now because their transaction costs outweigh their benefits. A reporting threshold would reduce administrative burdens, but that would be true for **any** mechanism that decreases the number of cases to be reported. If the reduction of administrative burdens is a critical goal, reporting authorities could be required to report only those cases involving "repeat offenders". Others have suggested that those with more than one report in the NPDB are the only individuals, if any, whose names should be made available to the public.[12]

In summary, setting a threshold for reporting malpractice payments to the NPDB may not only fail to achieve the goals of threshold proponents, but may also frustrate the legislative intent manifested by the NPDB.

REFERENCES

1. 42 U.S.C. § 11131.

2. Department of Health and Human Services. National Practitioner Data Bank Statistical Summary. Rockville, MD: Department of Health and Human Services; Nov 1993.

3. 42 U.S.C. § 11101.

4. *Medical Malpractice: Hearings Before the Subcommittee on Health and the Environment of the Committee on Energy and Commerce*, 99th Cong., 2nd Sess. 286 (1986) (statement of the American Hospital Association).

5. Id.

6. Medical Services Division, St. Paul Fire and Marine Insurance Company. Physicians & Surgeons Update: Annual Report to Policyholders. St. Paul, MN: The St. Paul Companies, Inc.; 1993:7.

7. Gianelli DM. Should it go to the bank? American Medical News. 1992 Sep 21;29.

8. Granville RL, et al. Some characteristics of Department of Defense medical malpractice claims: An initial report. Legal Medicine Open File. 1992; 92-1:1-10.

9. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660 (1986).